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AUTHOR Torres-Gil, Fernando
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ABSTRACT

The study examined the utilization of health care facilities, the barriers to utilization, the need for health services, the coping mechanisms (family, religion, folk medicine, or other vehicles used by older persons to help cope with health problems), and the way in which the different phases (prevention, initial utilization, and maintenance) of the health cycle were affected by cultural and socioeconomic factors. Data were derived from three surveys conducted in Colorado, San Antonio, and East/Northeast Los Angeles. In Colorado, 1,420 persons 55 years and over were personally interviewed in late 1973 and early 1974. The San Antonio survey was conducted in 1975 with interviews of 200 older Chicanos (123 women and 77 men), 55 years and over. The Los Angeles survey, which provides the majority of the data presented in this study, was conducted in 1975 with 179 Mexican Americans 55 years and over. Among the findings were: lack of income and transportation, folk medicine, his culture, the family, and discouraging institutional policies (i.e., geographic location, language barriers, class-bound values, and culture-bound values) were identified as playing a role in the ability of elderly persons to use health care facilities; folk medicine, the family, and the church were used as coping mechanisms to assist the older persons in surviving a health system which tends to exclude him; and most did not seek medical services due to a lack of finances and/or insurance to pay the costs. (NQ)

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AGE, HEALTH AND CULTURE: An Examination of Health Among Spanish-Speaking Elderly

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by

Fernando Torres-Gil, Ph.D.
University of Southern California
Andrus Gerontology Center
Los Angeles, California

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ABSTRACT

The paper examines the health status of the Spanish-speaking elderly by focusing on utilization of health care facilities, barriers to utilization and the need for health services. Given that little has been written before on this topic, a review of the general literature on health and Hispanics is presented and specific factors affecting utilization are identified. Data from three surveys are used to illustrate health problems and issues related to health among Mexican-Americans. Various factors (lack of income and transportation, folk medicine, culture, the family, discouraging institutional policies) are identified as playing a role in the ability of elderly persons to use health care facilities. A conceptualization of the health cycle into three distinct phases (prevention, initial utilization, maintenance) is developed to address the questionodf which factor affecting utilization is important in any given phase. Coping mechanisms (folk medicine, the family, the church) are also described as resources assisting the older person in surviving a health system which tends to exclude him. Recommendations are offered to planners and decision-makers to improve access to health care systems.

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AGE, HEALTH AND CULTURE:
AN EXAMINATION OF HEALTH AMONG OLDER MEXICAN-AMERICANS

There is sufficient evidence to indicate that Chicanos, Puerto Ricans and other Latinos suffer severe health and mental health problems which are not adequately addressed by the health delivery systems in the United States. More often than not these systems are not sensitive to the special cultural, economic and social pressures facing Spanish-speaking individuals. In this light it is quite appropriate that a conference has been called that seeks to lay the basis for the formulation of more effective health and human service policies for the Hispanic people of this country.

It is especially admirable, in the author's opinion, that particular attention is to be given to the Hispanic aged, las personas de mayor edad. For this group rightly symbolizes our culture and our past at the same time that it bears the brunt of many of the problems our people face today: the break-up of the traditional extended family, forced assimilation, discrimination, insensitive government practices, citizenship difficulties, lack of adequate housing and transportation, low educational opportunities and language discrimination.

According to the 1970 census data, there were approximately 382,000 Spanish-speaking persons over the age of 65. Of these, 189,000 were Mexican-Americans, 34,000 were Puerto Ricans and 35,000 were Cubans. This is out of an estimated Spanish-origin population of 9,000,000 of which 5,000,000 are Mexican-Americans.

Of course these demographic figures must be viewed carefully as inadequate census procedures have tended to undercount the Spanish-speaking population. The figures given for the Spanish-speaking elderly are at best estimates. This is particularly true because of the large number of Spanish-speaking people in this country who do not have legal entry documentation. Older Latinos are especially reluctant to participate in census studies because of the threat of deportation. Nevertheless, existing demographic information about the Spanish-speaking elderly reveals a very low socio-economic level. Thirty-two percent of the Spanish-speaking elderly are classified as poor compared to 25% of white elderly. The figure for Mexican-American elderly is higher at 37%. Approximately 16% of Spanish-speaking men and women over 65 have completed high school compared with 38% of white elderly. Only 7% of Mexican-American elderly reached this educational level.

Like elderly everywhere, the Spanish-speaking elderly face many problems associated with old age. They are confronted with the increasing difficulties of illness-- often chronic -- and other physical disabilities. Many older Latinos live in substandard housing which they cannot afford to repair, particularly in the barrios of larger cities. Others are forced to rely on public housing or subsidized housing for shelter while still others live with family or relatives. With increasing age comes the loss of reflexes, perception and skills necessary for driving. Many older Latinos are forced to rely on public transportation (bus or taxi) which may be inaccessible or too expensive. Alternately, they may

be forced to rely on their extended family for transportation, a situation which may serve to undercut the elderly individual's sense of independence.

As is well known, elderly individuals of all races are often ignored by an American society which places such great value on youth, energy and beauty. Older people in general must face many negative stereotypes which contribute to their unfortunate plight. They are often viewed as senile, conservative, asexual, apolitical and even useless. The respected and valued roles within the professions, family and society that older people once held are mostly a thing of the past. Older Latinos however, have some advantages in this regard because they are tied more closely than their white counterparts to the traditions and customs of their cultures-- traditions and customs which provide a respected and even exalted position for the older person. In many areas of this country, particularly rural areas, one can still find the older person acting as authority head, matriarch or patriarch, provider, transmitter of the culture and counselor-- positions which give him or her a valuable role in the community (Sotomayor, 1973). Shelter, food and love are mutually reciprocated between the older person, the family and the barrio. But even among the Spanish-speaking it appears that these traditions are breaking down in some areas, particularly in the urban cities of the Southwest and East coast. Disquiting evidence exists that the older person is becoming more isolated and alienated than had once been the case. More older Latinos find themselves living alone in housing projects or

subsidized housing with little interaction with family members. Urbanization and acculturation of the young combine to lessen the valued roles of older Latinos. In addition, the Spanish-speaking elderly must face problems unique to them. Many were born outside the United States and thus have citizenship problems. The Mexican-American must particularly be wary of immigration authorities who may threaten deportation or loss of citizenship.

Among all the problems facing Hispanic elderly, however, health is perhaps one of the most troublesome. The normal infirmities brought on by advancing age are compounded by the previously mentioned social and cultural difficulties. Unfortunately, very little research has been undertaken which seeks to explore this pressing area of social concern. Neither does there exist a quantity of data which would help to document specific problems and the frequency of such problems.

Not surprisingly, given the state of research in this area, there is as yet no comprehensive review of the literature on the health and mental health status of the Spanish-speaking population.

The initial review that follows therefore, will help to point up the vastness of the gaps in our knowledge while also helping to establish a preliminary background for a deeper examination of the issues.

LITERATURE REVIEW

To date, attention has not been paid to the health and mental health situation of older Spanish-speaking persons as distinct from the Spanish-speaking population as a whole. Such problems as the utilization of service, availability and obstacles to these services also have not been explored. Additionally, no research to speak of has addressed itself to the problems facing Spanish-speaking groups otherthan Chicanos.* Instead, the literature available, has focused almost entirely on the subculture of health among Mexican-Americans (folk medicine, fatalism, religion), utilization of mental health facilities and explanations for lack of services.

Weaver (1972) provides a useful categorization of research on Mexican-Americans' health-care behavior. He described and criticized three generations of research orientation. The first generation is identified as anthropological in approach with a reliance on cultural attributes to distinguish and explain health-care behavior among Mexican-Americans, primarily in the 1940's. Saunders (1953, 1954, 1956) placed health-care behavior in a cultural prespective and developed a theory that there are four basic sources of Chicano health-care knowledge and treatment:

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*Due to the absence of any previous work on the health problems of Puerto Rican, Cuban or other Latino elderly, this paper, unfortunately, has had to restrict itself solely to the situation of the Mexican American. All future uses of the term "Spanish-speaking elderly" refers only to the Chicano aged.

1. folk medicine of Mexico, 2. folk medicine of one or more native American tribes, 3. anglo folk medicine, and, 4. scientific medicine. In this light, Saunders focused on folk medicine culture and its impact on preventive health. He perceived the more negative aspects of folk culture, such as diseases caused by magic about which little can be done as well as the negative aspects of family and time, e.g. illness seen as a social event, thus giving rise to the avoidance of hospitalization and the 'manana' syndrome.

The second generation of health studies was conducted in the 1950's and characterized by Clark's study in a San Jose barrio (Sal Si Puedes, 1959), Rubel's in Hidalgo County, Texas (1966), and Madsen's in South Texas (1964). These studies were patterned after Saunders' work and in many cases built upon his findings, concentrating on folk medicine and attempted to culturally interpret health behavior. The studies supported the subculture thesis that patients treat themselves, are treated by family or friends, or visit curanderos and are not concerned about time or efficiency. All these factors are then seen as forming a barrier to effective utilization of scientific health care.

In retrospect, these studies were notable for two reasons: they continued to rely on participant observations of small samples and had a large impact on a generation of students and academicians who utilized their findings, overgeneralized them and thus contributed to myths and stereotypes about Spanish-speaking persons.

Jaco (1959) was one of the first to rely on a survey research rather than anthropological methodology. Whereas others had relied

on small samples of rural working-class or peasant Mexican-Americans, he utilized approximately 11,000 records of psychotic patients and created a comparable profile of the incidence of mental illness. His main finding was that Mexican-Americans had lower rates of commitments to mental institutions, a fact he interpreted to mean that Mexican-Americans had lower levels of psychotic disturbances than Whites. Jaco also relied on a negative view of the Mexican culture symbolized by Ruben's comment that a major task of South Texas Valley physicians should be to change the Mexican-American culture in order to effectively use scientific health practices.

Weaver characterized the third generation of research on Mexican-American health needs as the "emergence of the Chicano." He stated that this generation of the 1960's utilized survey research, contradicted as well as confirmed previous research and continued to concentrate on narrow segments of the population. In addition he noted the influences of Chicanismo on interpretations and orientation of this era's research.

Survey research by Moustafa and Weiss (1968) investigated mortality and utilization rates. Clark (1959) examined the fear that Mexican-Americans exhibit in regard to health workers and investigators. Mall and Speilberg (1967) argued that the family had a negative impact on health care and Kiev (1968) more elaborately identified fatalism odeipal patterns, dignidad, stoicism and other cultural traits as having a negative impact on health care practices.

On a more positive side, Karno and Edgerton (1969) utilized survey research to examine mental health practices of Mexican-

Americans and found a marked underutilization of psychiatric facilities. Other recent research has shown a greater concern with the importance of investigatingssuch variables as class, education, age, residence, family size as well as an increased awareness of the stereotypes, misinterpretations and overgeneralizations which plagued prior research.

In mental health-related research the literature focuses on the relative incidence of psychological service utilization by Mexican-Americans. Some found a lower rate (Jaco, 1959) (Karno and Edgerton, 1969) while others found a higher rate (Wignall and Koppin, 1967 and Saunders, 1954). A few writers have suggested that the family provides support in the face of mental breakdown (Jaco, 1959, 1960 and Madsen, 1964) while others have suggested that faith healers rather than professionals may explain underutilization (Karno and Edgerton, 1969).

This brief review of the literature serves to highlight several issues critical in discussing the health status of Mexican-American elderly. Most obvious of course is that no published works are available that deal exclusively with older Spanish-speaking persons. A total lack of knowledge has existed for many years about this group and their health status, needs and problems. References are seldom made to age as a variable nor are the roles of the older person in the family, culture or society discussed. Little has been known about the older person's access to health facilities or his distinction between health and mental health: two areas of prime importance of health among

older persons. Few, if any studies, have made use of medical examinations, medical service utilization or the relative importance of various factors (socio-economic status, age, language) to health services utilization. Most research has focused on the characteristics of traditional Mexican-American culture that may affect the interactions of Mexican-Americans with the American health delivery system.

Previous research has also had a total disregard for policy oriented issues: What programs are best suited for older persons? Where should they be located? Who will fund such programs given the lack of financial resources in the barrios?

HEALTH STATUS AMONG THE SPANISH-SPEAKING ELDERLY

Health care delivery systems in this country are theoretically designed to serve all segments of society; rich and poor, minority and non-minority, educated and not-so educated. Access to these systems is supposedly open to all. In the real world, however, this is frequently not the case. To a large degree, Chicanos and other minorities are effectively excluded.

The current standard health delivery system contains many entry and treatment points: clinic, general hospitals, optometrists, pharmacies, podiatrists, long-term care facilities, drug manufacturers, specialized medical facilities, public health facilities, etc. This system, with its myraid services and entry points, becomes complicated and expensive to navigate. Bilingual-bicultural persons appear to be exluded from these services because of the system's complicated and expensive nature as well as its insensitivity to many social, cultural and political features unique to the Spanish-speaking elderly.

The purpose of this paper will be to examine the utilization and non-utilization of various facets of the health delivery system by the Spanish-speaking elderly. Of major importance will be a discussion of coping mechanisms (i.e. family, religion, or other vehicles used by older persons to help cope with health problems) and an examination of the way in which the different phases of the health cycle are affected by factors related to cultural and socio- economic

status, and recommendations for improving health delivery systems to the Spanish-speaking population.

The data presented is derived from surveys taken in three geographical areas: Colorado, San Antonio and East/Northeast Los Angeles. The Colorado study took the form of personal interviews conducted in late 1973 and early 1974. Approximately 4.5% of the sample drawn from 18 counties were minority elderly (65% were Chicanos). The total sample included 1,420 persons (20% Indians, 15% Asians and the remainder Mexican-Americans) 55 years and over.

The San Antonio study was conducted in 1973 with interviews of 200 older Chicanos (123 women and 77 men), 55 years and over. The East Los Angeles Health Task Force (ELAHTF) study, which provides the majority of the data presented here was conducted in 1975 in Northeast and East Los Angeles. It utilized a representative stratified sample of 179 Mexican-Americans 45 years and over.

How did the Mexican-American elderly perceive their health status? In San Antonio, 35% of women and 46% of men respondents categorized their health as poor. In East Los Angeles, 37.5% of males and 44% of females over 60 years of age categorized their health as poor to very poor. In addition, 53% of the males and 41% of the females considered themselves disabled. When asked if a health provider at any time within the last year had judged them as being disabled, the elderly answered affirmatively in almost the same proportions as when asked if they considered themselves disabled.

What are some of the major health-related physical problems

older Latinos face? The Colorado study showed that difficulty getting up and down stairs was the most frequently mentioned (31.5%) followed by shopping for groceries (28.9%), vision (27.8%), hearing (24.2%), eating solid foods (21.2%), remembering (19.8%) and getting out of the house (19.8%). The mean number of difficulties per person was 2.1 with no sex differences.

In East Los Angeles, among 64 respondents who considered themselves disabled (including the total sample of those 45-59 and 60 years and over), arthritis and related diseases (18%) were the greatest problems followed by diabetes Mellitus (11%), cardio-vascular diseases (11%), nervousness and debility (9%), accidents and injuries (6%) and cerebral vascular diseases (5%).

The data from these studies shows rather conclusively that the health situation of the older Mexican-American-- whether in the rural areas of Colorado or urban areas of Texas or California-- is far from good. Such findings of course, are not altogether surprising given the age and low socio-economic status of this group. But this data just barely scratches the surfaces. Other issues related to the availability and utilization of health care servies, must be furthered explored. More specifically, we need to look more closely at such issues as: the desire of the Chicano population for more effective health care, both medical and preventive, barriers in utilizing health care facilities, the failure of researcher, planners and decision-makers to make the health care delivery system accessible, and reliance by older Mexican-Americans on available coping mechanisms (the family, folk medicine, religion).

Utilization of Health Services

To what extent do older Latinos use health care services? The following tables derived from the data of the ELAHTF illustrates the use of physicians, dentists and other health professionals among the older sample 60 years and over.

Table I

HAVE YOU CONSULTED A -- WITHIN THE LAST YEAR?
(Chicanos 60 and over)

	Male (N=32)		Female (N=54)	
	YES	NO	YES	NO
Physician	28 (87.5%)	4 (12.5%)	52 (96%)	2 (4%)
Dentist	9 (28%)	23 (71.8%)	15 (27.8%)	39 (72.2%)
Eye Doctor	18 (56.2%)	14 (43.7%)	28 (51.9%)	26 (48.1%)

As can be seen, of the three, physicians and eye doctors are consulted most frequently. The mean number of consultations by males 60 and over within the last year was 13 and for females it was 8.

Of note in the above table is the wide use of physician by elderly-- a finding which is consistent with those findings from a larger study of Los Angeles County households showing consultation of physicians to be the most frequent form of health care used by older people (1976). Some observers have suggested that physicians are perceived by elderly Mexican-Americans as a cure-all or a centralized health aid for all illness not able to be treated at home, including mental health problems. This data tends to

confirm such impressions.

When asked their reasons for consulting a physician within the last year, responses included diabetes (7), hypertension (4), gastrointestinal diseases (6), and musculo-skeletal arthritis (5). For females age 60 and over, the breakdown was as follows: hypertension (19), diabetes (14), influenza/colds (10) and examinations (19).

Table II

	Male (60+) (N=32)		Female (60+) (N=54)	
	YES	NO	YES	NO
Stayed overnight in hospital as patient within last year	13 (40.6%)	19 (59.4%)	11 (20.4%)	43 (79.7%)
Received health care at a clinic within last year	11 (34.3%)	21 (65.6%)	18 (33.3%)	35 (64.8%)
Friend or family provided home health care while ill	16 (50%)	16 (50%)	25 (46.3%)	29 (53.8%)

The data displayed in Table II lends further support to the observation that physicians consultations are the most widely used health service by elderly Mexican-American. However, it is interesting to note that approximately 50% of the respondents indicated that they received home health care provided by a friend or relative. The relatively high use of this resource may be attributed to the

high cost of other care, alienation from or lack of access to other forms of institutional care, or the positive supportive role of friends and family.

Clinics visited included both private and government controlled facilities such as county health services or outpatient clinics of public hospitals. Only one person from the total East Los Angeles sample (45-69, 60+) indicated visiting a neighborhood free clinic.

The large number of elderly who relied upon home health care by a relative or friend is particularly significant when compared to the finding that only one male aged 45-59 and one male 60+ had been in an extended care facility within the last year. Is this discrepancy in the care of chronic illness among Chicanos brought about because the elderly Chicano naturally looks toward his or her family for care? Or is it because extended care facilities and nursing homes, while needed, are alienating to these Spanish-speaking people?

The need for health care and the demand and necessity for personal health services is apparent. The large percentage of respondents who stated their health as poor to very poor, their reliance on physicians and the prevalence of chronic illnesses which usually require follow-up care offer substantial proof of serious health problems. But how readily do the Spanish-speaking elderly receive medical care necessary for improvement and maintenance of health? The East Los Angeles study addressed this issue when the respondents were asked whether they had felt the need for

medical services in the past year but did not seek care. The following table shows the breakdown for the total sample.

Table III

Male	YES	NO	TOTAL
45-59	11 (26%)	31 (74%)	42 (100%)
60+	10 (31%)	22 (69%)	32 (100%)
Female			
45-59	27 (53%)	24 (47%)	51 (100%)
60+	23 (43%)	31 (57%)	54 (100%)

This data dramatically illustrates the felt need for greater health services. Thirty-one percent of males 60+ and 43% of females felt they did not receive medical care when needed. In the younger age category, where maintenance of health is critical in minimizing the debilitating effects of older age, fully 26% of males and 53% of females felt they did not receive care when needed. Female respondents in particular appeared to have the greatest felt need for medical care.

Barriers to Utilization

What factors may account for the above-mentioned perceptions by Chicano elderly that they are not obtaining needed care? Is this due to a reliance on folk medicine or the extended family? Are health services insensitive to the needs of this group? Or are they perhaps simply inaccessible? These questions have direct implication for health delivery systems. Although the East Los Angeles study is the only study to document the desire for medical

services, it safely may be generalized that this need is as acute in other locations where large concentrations of Hispanic and elderly reside. It should be remembered that Los Angeles Chicanos reside in an urban environment where economic and social opportunities are supposedly more readily available (Grebler, Moore and Guzman, 1970) than other areas in the Southwest. If the health delivery system is to improve its services to older Spanish-speaking persons it must identify those factors that affect utilization of such services and their relative importance under varying circumstances.

Padilla, Ruiz and Alvarez (1975), in perhaps the best work on the subject, discussed factors associated with delivery of mental health services to the Spanish-speaking population. Although their paper focused on mental health, it proves useful in a more general discussion of utilization of health services among older Mexican-Americans. Padilla, et.al., asserted that the Spanish-speaking population received mental health care of a different kind, of lower quality and in lesser proportions than any other ethnically identifiable population. They identify specific variables which have been posited as explanations for this underutilization:

1. Lower frequency and severity of mental illness

Several reports (Jaco, 1959 and Madsen, 1964) found underutilization of mental health resources and suggested that Spanish-speaking persons are better prepared to tolerate stress and require less support from social institutions. However, other writers (Karno and Edgerton, 1969 and Terry, 1968, 1969) suggest that the Mexican-American population is subjected to more stress and tension

because of social, economic and cultural pressures arising from living within a larger white society.

2. Use of folk medicine and/or faith healer

Reliance on traditional folk culture has been a favorite area of study for many researchers. One result of this emphasis, however, has been the creation of the stereotypic conception that folk remedies are regularly selected as alternatives solutions for emotional problems, or as substitutes for utilizing the health system. The role of the family in health behavior, although not included in Padilla, can be also considered a cultural factor affecting health practices. The family, especially in earlier studies of health among Mexican-Americans, has been considered a source of emotional support which through its dependency ties, discourages members from utilizing hospitals, psychiatrists or doctors.

3. Discouraging institutional policies

This category concerns organizational factors and institutional policies which discourage greater utilization. Long waiting periods, inflexible intake procedures and insensitivity of health professionals are examples of institutional barriers. These factors fall into the following subcategories:

a. Geographic isolation. Mental health programs are frequently inaccessible because they are located outside of the barrio, because of inadequate transportation facilities or because of the adsence of child care centers.

b. Language barriers. Many Mexican-American elderly speak Spanish as their first language speaking little or no English.

The absence of interpreters or bilingual personnel would directly affect utilization for those not speaking or understanding English.

c. Class-bound values. The middle class values by professional staff are seen as conflicting with values associated with persons from a low socio-economic background. One example frequently mentioned is the formal time schedule followed by hospital and clinic staff conflicting with the more flexible time schedules often used by poor people. Another example relates to emergency care.

Sudnow (1967) in an article on a county hospital's method of dealing with emergency cases, documented the class bias of medical staffs. He concluded that there is a strong relationship between age, social background and the perceived moral character of patients and the amount of effort expended in emergency care. The elderly and alcoholic were the two groups given the least consideration by the staff. The second-rate care offered in some emergency cases may have even been responsible for some unnecessary patient death.

d. Culture-bound values. Culture conflict is seen as occuring when therapists and other professional staff view Spanish-speaking clients as hostile, suspicious, illiterate and provincial. These conflicts are rooted in the insensitivity of many white professionals to the bilingual-bicultural characteristics of the Mexican-American.

In assessing obstacles to utilization of mental health centers, Padilla, et.al. believed that the alleged ability of Mexican-Americans to cope with emotional problems and utilize folk

medicine as substitutes for modern medicine are not valid explanations. Instead, they concluded that the major explanatory variables are associated with discouraging institutional policies. In particular, Padilla et. al. cited language, class and culture bias as the major factors actively discouraging utilization of mental health services among Mexican-Americans.

Although Padilla's article focused on mental health of the general Chicano population, it provides a framework for identifying specific factors negatively affecting utilization of the health delivery system by older Mexican-Americans. All the factors mentioned are important ingredients in the health care behavior of older Mexican-Americans. It is reasonable to assume that the older person is affected by each of the factors described, but in different manners and degrees. While data with which to evaluate barriers to utilization of health services among older Mexican-Americans is difficult to obtain, a start in this direction has been made by the Colorado, Texas and particularly the East Los Angeles studies.

Data from the East Los Angeles Study

In the East Los Angeles Health Task Force Study (ELAHTFS) a large percentage of Mexican-American elderly stated that they did not seek medical care even if they felt a need for it. Their reasons for not seeking medical care were as follows:

Table IV

Men	Lack of finances and insurance	Medicare/Medical problems	Lack of transportation and/or personal assistance
60+	9 (64%)	1 (7%)	3 (21%)
Women			
60+	17 (52%)	6 (18%)	6 (18%)

Men	Lack of trust with health providers	Other	Total
60+	0 (0%)	1 (7%)	14 (100%)
Women			
60+	2 (6%)	2 (6%)	33 (100%)

The major reason given for not seeking medical services was a lack of finances and/or insurance to pay the costs. The second major reason was that lack of transportation and personal assistance kept them from seeking medical services. These major reasons held for the total sample of middle aged and elderly respondents.

Another question further probed obstacles to utilization of health services. The respondents were asked: "In thinking back over your experiences with health providers what have been the most serious obstacles encountered in obtaining medical care?" The responses are illustrated in the following table.

Table V

Men	Lack of finances or insurance	Language barriers	Rejected for care? waiting to long
60+	10 (24%)	5 (12%)	5 (12%)
Female			
60+	23 (31%)	9 (12%)	6 (8%)

Men	Lack of transportation and/or personal assistance	Lack of trust with service provider
60+	8 (20%)	5 (12%)
Female		
60+	13 (18%)	4 (5%)

Men	Medicare/Medical problems	Insensitivity of person to culture and needs
60+	4 (10%)	22(5%)
Female		
60+	9 (12%)	3 (7%)

Men	Inadequate care given by provider	Total **
60+	2 (5%)	41 (100%)
Female		
60+	7 (9%)	74 (100%)

** Respondents could report more than one obstacle.

Again, the two most serious obatacles encountered by this sample of Mexican-American elderly were the lack of finances and insurance with which to pay for medical services and the lack of transportation and assistance. Language barriers were another

serious obstacle. Lack of income and transportation are correlated with low socio-economic status of older persons and their need for assistance in walking, driving, taking a bus or using a taxi.

For example in the Colorado survey the median income for minority aged was $174 per month. Thirty-six percent of the respondents owned their own car, 30% relied on relatives, 30% took buses and 25% walked. In San Antonio, the mean monthly income for women was $191 and for men $211 per month. In the East Los Angeles Health Task Force survey, males 60 years and over had a mean yearly family income of $5,773 ($481 monthly) and females 60 years and over had a mean yearly family income of $2,964 ($247 monthly). Clearly the older Mexican-American in these areas have very low incomes which affects their ability to pay for services and transportation assuming they do not posses adequate health insurance.

Medicare and Medicaal are intended to provide insurance coverage for hospitalization and medical treatment. However, there is evidence that this is only partially assisting older Spanish-speaking persons. A few years ago, Medicare covered almost 50% of the health needs of the elderly. Today it covers only slightly more than one third of their medical expenses. (newsletter from Asocia-cion Pro Personas Mayores, July, 1976).

THe ELAHTF study dramatizes the inadequacy of current health insurance coverage. Twenty-five persent of males 60 years and over and 37% of females 60 years and over were not covered by Medicare and/or Medical. Ninety-one percent of males 60 years and over and 85% of females 60 years and over had no health insurance other than

Medicare or Medical. Among the total sample 45-59 years of age and 60 years and over, 25% had no insurance coverage to meet any type of medical expenses, meaning that their medical expenses had to be paid entirely by out-of-pocket cash.

Clearly, folk medicine and cultural values are not the only important obstacles to health delivery. In fact, the evidence lends substantial support to the thesis that is is the inability of the health delivery system to allow access for older persons rather than the older person's unwillingness or an inherent inhibitory factor in his culture that is mainly responsible.

Coping Mechanisms

The older Mexican-American finding little help from existing health services has developed a rather intricate set of social mechanisms in order to cope with the onset of age-related health problems. These coping mechanisms are invaluabe assets and resources if recognized and incorporated not only in the health delivery system but in all social service delivery systems. In the broadest sense, the mechanisms are based upon a reliance on family, religion and culture. Unfortunately, as will be documented, these mechanisms are in danger of dissipating and disappearing once this age cohort of older persons has passed. The question arises, therefore, whether today's young and middle-age Chicanos will continue to use the old coping mechanisms or adopt new ones. If the latter is true then most certainly they will have to adjust to Anglo-oriented coping mechanisms that rely on a more impersonal, more profit-oriented relationship, one that is founded upon the governmental bureaucracy

rather than on individual's family or culture. If the former is true then we must find ways to maintain these more traditional mechanisms or at least adapt them to a changing modern society.

It should be stressed that these traditional coping mechanisms should not be seen as a substitute for a more humane, efficient and expanded health delivery system. Such a system is vitally needed and must remain our first priority. However, more subjective coping mechanisms need to be recognized, incoporated and maintained whenever possible.

1. Folk Medicine and Curanderos

In previous research, espetially in the 1950's and 1960's, folk medicine and curanderos were seen as the answer to understanding health care practices. Unfortunately, the interpretations resulting from such studies created stereotypes and overgeneralizations about the impact of folk medicine on the general Chicano population. However, if examined in a different context-- a context which includes folk medicine as one coping mechanism of older persons-- we begin to see these cultural manifestations as health resources rather than a novelty item to be studied by anthropologists.

In assessing health status of older Mexican-Americans, the ELAHTF survey attempted to determine the respondents' first course of action upon developing a health problem. The largest percentage of men and woman over 60 years of age answered that they consult a doctor (39% men and 50% women). A suprising persentage (22% men and 43% women) also answered that they take teas, yerbas and other home remedies. In the San Antonio study 80% of the female respondents and 70% of the male respondents had knowledge of medicinal herbs,

their usage, folk illness and their cure and where herbs and treatment could be obtained. This data leads us to conclude that many older persons do indeed believe in folk medicine and utilized its treatments.

Illnesses such as mal de ojo, empache, susto, and aire are treated by oral administration of various herbs: yerba buena, manzanilla, hoja se, estafiate and many older herbs. Application of liniments, oils and herbal mixtures, massages (sobadas) and regulation of diet are also used as treatments.

Treatments may be administered by anyone who has the knowledge. A patient may treat himself, ask a friend or relative who knows herbs and other cures or go to a curandera (a specialist in the diagnosis and treatment of folk syndromes). Although the full extent of the use of folk medicine among older persons is not known belief in them has long been standing and has strong emotional significance,

2. The Family

As has been the case with folk medicine, familism among Chicanos has been viewed as a deterrent to individual adjustment and social mobility among Mexican-Americans. The negative or conservative effects of familism have also been used to explain the health attitudes and behavior of Chicanos. Nall and Speilbery (1967), for example, suggested that the presence of relatives in the neighborhood and the process of those seeking advice from these relatives on private matters was related to the refusal of hospitalization for treatment of tuberculosis. Murillo (1971) also speculated that Chicanos were late for appointments because of their concept

of responsibility placed primary importance on the attendance to the immediate needs of their families. To the extent that these findings have validity, they are most applicable to the elderly, since it is this layer of the Mexican-American population that has the closest family ties. However, at the same time, the family clearly plays a very positive role in health care as an invaluable asset in providing financial, emotional and health care support. The family often is the center of the older person's social world, and, in turn the older person provides important functions. Sotomayor (1973) in a study of Chicano grandparents in a Denver barrio found that grandparents help in the rearing of grandchildren, solving family crisis, teaching religion and transmitting cultural heritage (language, values, food customs, history). On the other hand, the family will often accompany the older person to the welfare office, department of motor vehicles, store and to economic and social agencies, particularly if the older person does not speak English.

In the ELAHTF study, for example, it was found that the family frequently accompanied the older person to a health facility. The study showed that 44% of males 60 years and over and 52% of females 60 years and over did not usually go alone to receive medical care.

There is evidence that researchers are beginning to recognize the family as an important coping mechanism in utilization of health services. Hoppe and Heller (1975), in a study examining the influences of familism and occupational stability on alienation and

health care utilization, found that familism is an important coping mechanism which reduces feelings of alienation among lower-class Mexican-Americans and in turn influence the health care utilization behavior of this group.

It is hoped that all efforts will be made to encourage the family to assist and participate with the older person in health care maintenance and preventive aspects of health, such as health education. In turn the breakdown of the extended family in certain areas may be minimized and perhaps averted if governmental policy avoids regulations which force family members to let the older person handle an agency or institution on his own.

3. The Church

Many, if not most, older Mexican-Americans have relatively strong religious beliefs and attend church more often than other segments of the Chicano population (Grebler, Moore and Guzman, 1970). The church serves an important spiritual support for many older persons, helping them to face the pain, suffering and emotional crisis. In addition to continuing this spiritual support the church could also act as an important advocate and disseminator of health information because it often has direct access to many older persons who could not otherwise be reached (eg., those without proper immigration papers). Education about balanced inexpensive meals, about metabolic system needs (exercise and the dangers of obesity) and the location of social and service agencies are all examples of the consumer education needed in this area--information that the church could provide.

THE HEALTH CYCLE OF OLDER PERSONS: A CONCEPTUALIZATION APPROACH TO UTILIZATION OBSTACLES

Utilizing data from the ELAHTF and other similar surveys provides an invaluable opportunity for identifying barriers in accessing health delivery systems. However, it is also important to take a broader perspective on the total health cycle of older Mexican-Americans. The previously mentioned data reflects only one phase of health care practices among Chicanos.

In reality there are a number of distinct phases in the health cycle of the elderly Mexican-American, each affected differently by the previously discussed variables (folk medicine, culture, institutional policies).

Most of the data presented in this paper deals with initial utilization of a health facility. A person feels ill or gets hurt and seeks the services of a physician or goes to a county hospital or a clinic. But this is only the beginning of the health cycle, particularly among older persons with a distinct ethnic background. Decision-makers, researchers and planners must recognize that these distinct phases exist and that each requires the examination of a different set of variables in establishing areas for improvement of the health care delivery system.

The Preventive Phase

This phase deals with the prevention of sickness and accidents, or at least the minimization of such sicknesses or accidents. Older persons, because of a decline in physical capacities, are more susceptible to cardiovascular diseases, arthritis, hypertension and

accidents. A number of factors have a role to play in adequate prevention: nutrition, housing, income, knowledge of potential medical treatments, familial support and knowledge of existing health systems.

It has often been suggested that the current health delivery system is not geared toward a high level of involvement in this preventive phase. However, it seems reasonable to assume that the health system's role in this phase could be significantly augmented by incorporating and utilizing existing coping mechanisms derived from folk medicine, the family and the church.

The Initial Utilization Phase

This phase has been the focus of the data presented in this paper. It deals with the initial utilization of hospitals, clinics and physicians. Lack of income, poor transportation and inadequate health insurance have been shown to be the most important variables in initial access to the health delivery system.

The Health Maintenance Phase

Health care delivery involves more than the treatment of illness. It is supposed to minimize the needs for treatment of diseases or accidents through positive and pro-active programs of health maintenance. After the initial utilization of the health service it is critical to the older person that comprehensive follow-up procedures be undertaken and that the patient feels comfortable in whatever health facility he or she may be situated. It is in this phase where culture and class-bound values, as well as language and familial support, play an important role. For

example, the attitudes and values of health professionals will play an important part in determining the utilization by elderly Chicanos of both the out-patient and extended care facilities. Hostility towards Chicanos, insensitivity to cultural and class values, lack of bilingual personnel and discouragement of extended visits or accompaniment of family members all will serve to discourgage the older person from adequate follow-up care.

Padilla et.al. (1976) make mention of frustration among personnel in mental clinics when faced with high numbers of Spanish-speaking people who failed to return to the facility after an initial visit. Padilla blames this situation on the difference in social class characteristics between the mental health professionals and their patients as well as the lack of bilingual-bicultural personnel.

In summary then, this conceptualization of three distinct phases in the health cycle of an older person is intended to identify factors inhibiting utilization and specifying degrees of importance according to the particular phase. It has been the inability of past research and planning to recognize or accept phases such as these and the way in which varying social and cultural factors influence these phases that has prevented a more realistic critique of the health delivery system and subsequent improvements. It is hoped that planners and researchers will examine these areas further.

Given the current state of knowledge what policy recommendations can be made for improving access to the health delivery

system by older Spanish-speaking persons? While highly specific recommendations are perhaps premature, one thing is clear: that the health status of Spanish-speaking elderly overlaps with nutrition, income, transportation, culture and other such variables.

A recent APA article (1976) described the American health system as a large and complex set of facilities and services. It is a system characterized by a lack of coordination of such services as clinic, general hospitals, optometrists, pharmacies, podiatrists, long term care facilities and drug manufactures. For example, in East and Northeast Los Angeles, where the ELAHTF study was conducted, there are 12 hospitals, 14 emergency care facilities, 28 clinic, 17 nursing homes and three mental health facilities for a population of 361,573 (of which 257,968, or 71% are Spanish-speaking). Twenty-one percent, (54,462) are 45 years of age and over and of these 32% are 65 years and over. The most conspicuous health facility in this area is the mammouth Los Angeles County-University of Southern California Medical Center (LAC-USC) which includes the county general hospital.

Is it any wonder that, on top of all other factors impinging on utilization, an older person speaking little English would find it difficult to know how to use this complex health system? If he is forced to pick and choose a specific facility without knowledge of this vast apparatus, has little money and finds it difficult to get around, more likely than not an elderly Chicano in need of health care will either do nothing about his problem, rely on family or friends or go to the only medical resource with which

he is familiar, the physician.

It is this writer's contention that lack of coordination of health services and public knowledge about them serves to discourage the older persons from taking advantage of existing facilities. While there are clinics, mental health centers and hospitals in East Los Angeles, for example, what is needed is a comprehensive health center located near the clientele and offering a variety of services. This comprehensive health center could conceivably include a health component, nutrition center, day care facility and a mental health clinic, all linked with the community by transportation programs such as Dial-A-Ride.

The role of mental health among older persons highlights the needs for such a health vehicle. Observations point to the lack of distinction Latino older people make between health and mental health, particularly among older Latinos. Additionally, there is a social stigma attached to mental illness and psychiatrists.

Various writers point to the underutilization of mental health services (Jaco, 1959, 1960, Madsen, 1964, Karno and Edgerton, 1969, Padilla et. al., 1976). Various explanations have been offered, such as lack of mental disorders, use of folk medicine as substitute, insensitivity of mental staff, etc. But for older persons, no such examination of utilization has been offered. It is not difficult to imagine, however, that the elderly Chicano's tendency to use physicians for all manners of illness marks a significant underutilization of mental health center. Whether this section of the population evidences a lower frequency of emotional

of mental crises seems doubtful. The effects of urbanization and the demise of the extended family almost certainly lead to depression and alienation for many. We can assume with some certainly that a significant portion of elderly Chicanos require mental health services by professionals sensitive to bilingual-bicultural characteristics and that, therefore, the integration of a mental health component into a comprehensive system would be an important element in a more effective health delivery system.

Incorporation of nutrition centers would be another important component of such a system as adequate nutrition is vital to health prevention and maintenance. Nutrition centers also serve to draw out the isolated elderly who seek social companionship. It has been observed that many older persons using nutrition centers and other social service agencies frequently have grandchildren with them. A day care facility would probably encourage utilization by older persons who are baby sitting or who frequently care for young children. Although at present its appears that Mexican-Americans rarely use extended care facilities or nursing homes, it is likely that this will change in the future. Developing such a facility within or near a comprehensive health center would serve to keep the elderly close to their resources, neighborhood and family.

Existing transportation systems such as Dial-A-Ride, jitney services and subsidized taxis would be better able to transport elderly people to needed services in a centralized facility. Conversely, the center would be in a position to utilize government funds to establish demand-response transportation programs.

An example is currently provided by the Community Mental Health Care Centers pf centralized services under one roof. The centers (approximately 520 are in operation) are designed to provide such services as in-patient and out-patient care, day care and partial hospitalization and emergency services, consultation and education services, assistance to courts and other agencies in screening, follow-up for discharged mental patients and half-way housesservices. Recent legislation to the Community Mental Health Care program mandates that 10% of funds and services be provided for specialized services for the elderly. NIMH is currently developing regulations to meet the mandate of this new act. This is a hopeful sigh that older persons will be entitled to the services of a community mental health center.

RECOMMENDATIONS

Regardless of the way in which health care system re-organize themselves to provide greater access to older Spanish-speaking persons, it is important that certain vital health concerns be taken into account. Ortiz de Hill (1975) lists services which are of immediate importance to the Spanish-speaking elderly. These include:

1. Screening and resources
    a. A program which integrates community resources
    b. A service and treatment plan
    c. Manpower needs
    d. Information and education systems, Development of community awarenss
2. Nutrition
    a. Development of congregate meal sites
    b. Provision for home delivered meals (Meals on Wheels Program)
    c. Assistance with shopping and purchasing food
    d. Education about balanced meals
3. Home health care
    a. Visiting nurses
    b. Home health aids
    c. Telephone reassurance
4. Long term care facilities
    a. Plans and participation in milieu treatment
    b. Activity and community care teams

Further recommendations for improving the health status of older Chicanos include:

1. The development of a comprehensive care facility which is close to the barrio or in areas of high concentrations of older people.
2. That the new Health System Agency advocate and plan for these types of facilities.
3. That demand and response systems of transportation (Dial-A-Ride, subsidized taxis) be developed to assist the older person's mobility needs and be coordinated to get them to needed health facilities.
4. That preventive measures such as bilingual educational and information programs, early detection programs and annual screening examinations be established.
5. That health programs servicing Chicanos employ personnel who are sensitive to the culture, language and needs of the elderly person.
6. That a National Health Insurance program be voted into law.
7. That health planners and decision-makers give greater consideration to cultural aspects of the Spanish-speaking elderly and that their coping mechanisms be recognized and encouraged.

Summary

This paper has attempted to delinate areas affecting the health status of Spanish-speaking elderly through an examination of the health related literature, data which outlines various problems, and a conceptualization of phases in the health cycle and barriers to utilization. The implications, findings, and conclusions reached in this paper are, by necessity, preliminary and require more thorough research in this area. However, it is clear that the older Spanish-speaking person has serious health problems which are not being met and which cannot wait until extensive research and discussions have been held on the subject. It is hoped that this paper will serve as an impetus for politicians, decision-makers, advocates, and organizers to begin, now, to make the health delivery system more accessible to Spanish-speaking elderly and at the same time that researchers will provide more data on the issues raised in this paper.

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FOR ADDITIONAL INFORMATION WRITE:

Fernando Torres-Gil, Ph.D., Director
Research Dissemination and Utilization
Social and Cultural Contexts of Aging
Andrus Gerontology Center
University of Southern California
Los Angeles, California 90007